Gastric Cancer (2009) 12: 37–42
DOI 10.1007/s10120-008-0496-1

Original article

Phase II trial of S-1 for neoadjuvant chemotherapy against scirrhous gastric cancer (JCOG 0002)

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Abstract

Background. **The prognosis of scirrhous gastric cancer remains poor despite extended surgery or adjuvant or neoadjuvant chemotherapy. A pilot study of S-1 (TS-1; Taiho Pharmaceutical, Tokyo, Japan), an oral 5-fluorouracil derivative, for neoadjuvant chemotherapy unexpectedly showed good response and a promising effect on survival. Therefore, the Japan Clinical Oncology Group conducted a phase II trial to confirm the efficacy of S-1 for neoadjuvant chemotherapy against resectable scirrhous gastric cancer.**

Methods. **Patients were eligible if they had typical scirrhous gastric cancer invading more than half of the stomach, and resectable disease confirmed by laparoscopic staging. The treatment schedule consisted of two courses (each, 4-week administration and 2-week withdrawal) of S-1 (100–120 mg/body per day), followed by radical surgery.**

Results. **Fifty-five eligible patients were registered. Three completed only one course of the neoadjuvant chemotherapy, whereas 52 completed two courses. Toxicity was acceptable, with a few grade 3 (5.5%) events, but no grade 4 adverse events. The response rate was 32.6% in 43 evaluable patients. Of the 55 patients, 2 refused operation, 1 developed lung metastasis, and 52 underwent laparotomy. The curative resection rate was 80.8%, with acceptable morbidity and no mortality. The survival curve at 2 years' follow up showed a better survival rate than that of the historical controls, but did not reach the expected survival rate.**

Conclusion. **S-1 neoadjuvant chemotherapy appeared feasible and showed positive effects against scirrhous gastric cancer; however, the survival rate with S-1 did not reach the expected rate required when selecting an agent for a phase III trial to confirm the effectiveness of neoadjuvant chemotherapy against scirrhous gastric cancer.**

Offprint requests to: T. Kinoshita
Received: September 16, 2008 / Accepted: November 27, 2008

Key words Scirrhous gastric cancer · Neoadjuvant chemotherapy · S-1

Introduction

Scirrhous gastric cancer, also known as linitis plastica or Borrmann type 4, is a special type of stomach cancer known for its very poor prognosis. It is very difficult to identify this cancer in its early stage, and even aggressive surgical procedures and adjuvant chemotherapies have not considerably improved the survival rate in patients with this neoplasia. Owing to its low incidence, only a few drug trials against this neoplasia have been conducted thus far. On the other hand, several studies of neoadjuvant chemotherapy against scirrhous gastric cancer have suggested the efficacy of such treatment [1–4]. However, all these studies involved a small sample size and they usually did not determine the survival benefits of such treatment. Furthermore, a phase II trial of sequential high-dose methotrexate and fluorouracil combined with doxorubicin (FAMTX) for neoadjuvant chemotherapy has shown moderate toxicity and no survival benefits [5]. Interestingly, S-1, which is a dihydropyrimidine dehydrogenase (DPD)-inhibitory fluoropyrimidine, has shown the highest response rate among many oral anticancer agents against unresectable advanced gastric cancer in early and late phase II trials [6–8]. In these late phase II trials, S-1 showed a 33% response rate against scirrhous gastric cancer. Because of the reported promising effects of S-1 for neoadjuvant chemotherapy against scirrhous gastric cancer in a previous pilot study [9], the Japan Clinical Oncology Group

(JCOG) decided to conduct a phase II trial to determine survival benefits of S-1 treatment.

Patients, materials and methods

Patient eligibility

Patient eligibility required the fulfillment of the following criteria: histologically confirmed gastric adenocarcinoma; potentially resectable laparoscopy-confirmed typical scirrhous gastric cancer (without definitive ulceration) that invaded more than half of the stomach; received no prior treatment; 70 years or younger; Eastern Cooperative Oncology Group performance status of 0 or 1; and oral intake possible. Patients also had to have adequate organ functions (creatinine clearance, ≥50 ml/min; blood urea creatinine, within the institutional limit; GOT and GPT, within twice the institutional limit; leukocytes, 3500/mm^3≤ leukocyte <12000/mm^3; hemoglobin, ≥9.0 g/dl; thrombocytes, ≥1000000/mm^3; total bilirubin, within twice the institutional limit; and normal electrocardiogram).

Diagnostic and staging procedures included physical examination, barium gastrography, endoscopy, chest X-ray, abdominal computed tomography (CT) scan, and laparoscopy with cytological examination of peritoneal washing of the Douglas pouch. Patients with positive cytology on peritoneal washing and potentially resectable disease without visible peritoneal dissemination were also included in the study.

This study was approved by the Institutional Review Board, and written informed consent was obtained from all patients.

Treatment schedule

Chemotherapy consisted of two courses (4-week administration and 2-week withdrawal) of S-1 at 100–120 mg/body per day. After two courses of neoadjuvant chemotherapy, patients were reevaluated for the presence of potentially resectable disease and those who were positive underwent laparotomy. Because two patients underwent endoscopic examination after one course of chemotherapy and stopped chemotherapy due to progressive disease, the treatment protocol was revised such that the evaluation of the effect of neoadjuvant chemotherapy should be carried out only after two courses and only by fluoroscopic examination. If indicated, patients received curative or palliative resection or exploratory laparotomy within 14 days after completing the second course of adjuvant chemotherapy. Patients with curative resection were followed up without any adjuvant chemotherapy every 3 months until cancer relapse.

Evaluation of response and toxicity

Potentially resectable scirrhous gastric cancer usually shows no measurable lesions, except for primary foci. We decided to evaluate the response of only primary foci following chemotherapy. Because it is very difficult to evaluate the response of the primary foci using the Response Evaluation Criteria in Solid Tumors criteria, we used a National Institutes of Health (NIH) image to calculate the barium-filling area or whole stomach on a double-contrast fluoroscopic examination study, as well as to compare the area before and after chemotherapy. Responses were classified as partial response (PR), more than 50% increase in the area after chemotherapy; stable disease (SD), 0 to less than 50% increase in the area; and progressive disease (PD), any decrease in the area and the appearance of new lesions. National Cancer Institute Common Toxicity Criteria ver2.0 were employed for determining chemotherapy toxicity.

Pathological assessment was performed to evaluate disease extent, resection margins, and response to chemotherapy as evidenced by the presence of necrotic and cancer cells. The pathological response to chemotherapy was classified according to the following criteria provided by the Japanese Gastric Cancer Association [10]: grade 0, absence of necrosis or degeneration; grade 1a, necrosis or degeneration is observed in less than one-third of the tumor; grade 1b, less than two-thirds and more than one-third of the tumor show necrosis or degeneration; grade 2, more than two-thirds of the tumor shows necrosis or degeneration; grade 3, all tumors show necrosis or degeneration.

Historical controls

Because we applied laparoscopic staging to exclude patients with visible peritoneal dissemination, it was very difficult to find good historical controls. Laparoscopic staging had gained popularity at the commencement of this trial; however, we had no identical historical controls. The historical controls consisted of 241 patients who had the same lesions as those described in the eligibility criteria for this study, and who had no visible peritoneal dissemination at laparotomy without laparoscopic staging, and had been treated at the participating institution during 1991–1993. Data for the historical controls were as follows: 2-year survival rate, 45%; curative resection rate, 90.3%; 30-day operative mortality rate, 1.2%; and in-hospital mortality rate, 3.5%.

Statistical considerations

The primary endpoint of this study was the 2-year survival rate. Fifty-five patients were required to be registered on the basis of the expectation that the 2-year survival rate of those receiving this neoadjuvant chemo-

therapy would be 60% (15% higher than that of the historical controls), allowing 10% of ineligible patients. Survival time was calculated from the initial date of the initiation of neoadjuvant chemotherapy to the date of death or the last follow-up date. Survival data were analyzed according to the method of Kaplan and Meier and then compared with the data of the historical controls.

Results

Patient accrual

From March 14, 2001, to February 4, 2003, 55 patients were enrolled in the study from 15 institutions. The mean age was 56 years (range, 31–70 years).

Neoadjuvant chemotherapy

The patients were composed of 26 male and 29 female patients. The scheduled two courses of neoadjuvant chemotherapy were performed in 52 patients. The remaining 3 patients received one course, because 2 of the 3 patients were judged to have PD by endoscopic evaluation after one course before the revision of the protocol, and 1 patient was found to have advanced bile duct carcinoma after one course of chemotherapy. These 3 patients received curative resection after one course of neoadjuvant chemotherapy. There was no chemotherapy-induced grade 4 adverse reaction in the cohort. Only 3 patients developed grade 3 adverse reactions (Table 1).

As mentioned earlier, the effect of adjuvant chemotherapy was evaluated from the change in the barium-filling area before and after the chemotherapy, as calculated from the NIH images. Among the 43 patients whose fluoroscopic films could be evaluated, 14 patients (32.6%) showed more than 1.5 times enlargement of the stomach (PR); 13 patients showed SD (30.2%), and 16 patients showed PD (37.2%).

Table 1. Adverse reactions

	Grade				%	
	0	1–2	3	4	Grade 4	Total
T. Bil	32	23	0	0	0	55
WBC	42	13	0	0	0	55
Neutrophils	42	12	1	0	0	55
ALT	43	11	2	0	0	55
AST	45	9	0	0	0	55
Hb	48	7	0	0	0	55
Nausea/vomiting	36	19	0	0	0	55
Pigmentation	44	11	0	0	0	55
Anorexia	45	10	0	0	0	55
Diarrhea	45	10	0	0	0	55
Stomatitis	45	10	0	0	0	55
General fatigue	46	9	0	0	0	55

Only three patients developed grade 3 adverse reactions, and they recovered by withdrawal of S-1
T. Bil, serum total bilirubin; WBC, white blood cell count; ALT, alanine aminotransferase; AST, aspartate aminotransferase; Hb, hemoglobin

Operation

Among the 55 patients, 3 did not undergo operation, because of the refusal of 2 and because the other patient was found to have pulmonary metastases. Fifty-two patients underwent laparotomy, including the 3 patients who received one course of the neoadjuvant chemotherapy. Among the 52 patients, 6 patients did not undergo resection (5, peritoneal dissemination; 1, unresectable invasion of the duodenum and pancreatic head). Ten patients underwent palliative resection of the main tumor (2, peritoneal dissemination; 6, positive cytological examination of abdominal washing; 1, unresectable tumor with severe invasion to the retroperitoneum; 1, widespread lymph node metastases). The other 36 patients underwent curative total gastrectomy with various combined organ resections (25, spleen; 1, distal pancreas + spleen; 5, gallbladder; 2, left adrenal gland; 2, transverse colon; 1, pancreatic head and duodenum). Among the 36 patients, only 1 had D1 lymph node dissection and the remaining 35 had D2 or more lymph node dissection.

The mean operation time for curative resection was 214 min (range, 130–460 min) and that for noncurative resection was 295 min (range, 150–401 min). The mean blood loss for curative resection was 586 ml (range, 30–1815 ml) and that for noncurative resection was 872 ml (range, 230–2100 ml).

Among the 46 patients who underwent resection, postoperative complications were observed in 11 patients (23.9%). Overall, there was no mortality and there were no serious complications. The actual complications were as follows: wound infection, deep vein thrombosis, pancreatic fistula, anastomotic ulcer, pneumonia, pulmonary embolism, sepsis, abdominal abscess, liver function disorder, and mycotic uveitis.

Changes in the T, P, and CY (cytological examination of the abdominal washing) factors before and after neoadjuvant chemotherapy are shown in Tables 2 and 3. With regard to the T factor, a response was observed in 14 patients; however, cancer progression was observed in 8 patients. In regard to the P and CY factors, a response (PR) was observed in only 2 patients; however, 10 showed progressive disease (PD). The other 40 patients showed stable disease (SD).

The pathological therapeutic effects of neoadjuvant chemotherapy were evaluated according the grading described by the Japanese classification of gastric carci-

noma [10] general rules for gastric cancer study: grade 0, 12 patients (26.1%); grade 1a, 19 patients (41.3%); grade 1b, 4 patients (8.7%), and grade 2, 11 patients (23.9%).

At the time of the scheduled analyses (March 2005), 10 patients were still alive without recurrence, 13 were alive with recurrence, and 32 had already passed away. The modes of recurrence were as follows: peritoneal, 17 patients; retroperitoneal, 2 patients; local, 1 patient; lymph node, 1 patient.

Table 2. Changes in T factors before and after chemotherapy

Laparoscopic T		Pathological T
T2:7		T2:11
T3:39	Chemotherapy	T3:37
T4:5		T4:4
Tx:1		

Progression, 8 patients; downstage, 14 patients
Tx, T unknown

Table 3. Changes in P and CY factors before and after chemotherapy

No change or progression (SD and PD)	
P0, CY0→P0,CY0	37 (SD)
P0, CY0→P0, CY1	2 (PD)
P0, CY1→P0, CY1	3 (SD)
P0, CY0→P1	4 (PD)
P0, CY1→P1	4 (PD)
Downstage (PR)	
P0, CY1→P0, CY0	2 (PR)

The survival curves of all patients (n = 55) and the historical controls are shown in Fig. 1. The survival curve of the study arm was better than that of the historical controls; however, the survival rate did not reach the expected rate (2-year survival rate: 59% vs 60%).

With regard to the secondary endpoints, the response rate to the neoadjuvant chemotherapy was 32.6%. The rate of postoperative complications was 23.9%, as against 25.7% in the historical controls. The in-hospital mortality rate was 0% as against 3.5% in the historical controls. The curative resection rate was 80.8%, as against 90.3% in the historical controls.

Discussion

Despite recent advances in chemotherapy and extended surgery, the treatment outcomes of scirrhous gastric cancer, also known as diffuse gastric cancer, linitis plastica, or Borrmann type 4 in the West, have remained very poor because of the aggressive biological behavior of this tumor. Because of failure to improve survival even with aggressive postoperative chemotherapy, neoadjuvant chemotherapy has been applied to patients with resectable or unresectable scirrhous gastric cancer.

To date, the efficacy of neoadjuvant chemotherapy against scirrhous gastric cancer remains to be established because of the lack of well-validated phase II and phase III studies. The first phase II neoadjuvant chemotherapy trial was reported by Takahashi et al., using FAMTX [5]. In their trial, neoadjuvant chemotherapy was shown to be seemingly feasible against scirrhous

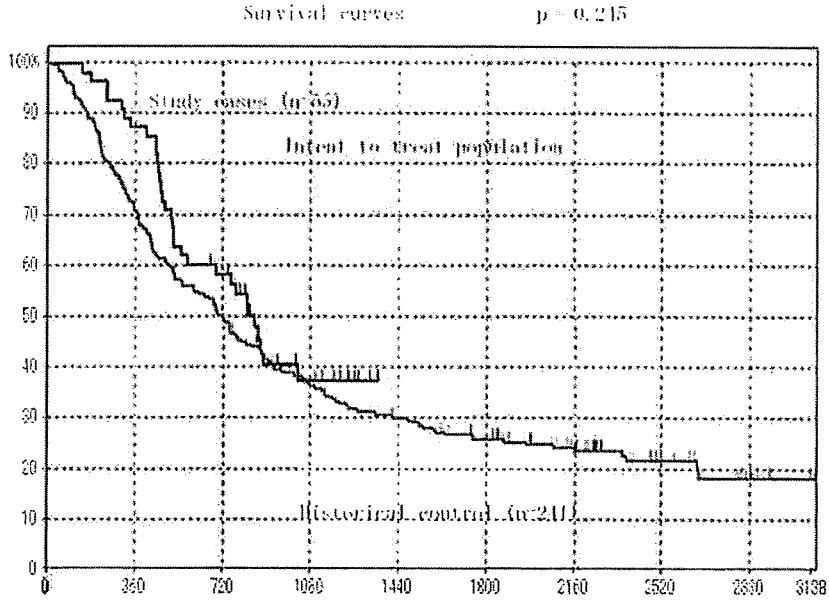

Fig. 1. Survival curves of all patients (n = 55) and the historical controls (n = 241)

gastric cancer, producing a higher resectability rate without any increase in morbidity rate. However, an interim analysis of the 2-year survival rate in 20 patients enrolled in the trial showed no improvement over the survival rate of the historical controls. Myelosuppression was the major cytotoxic effect of the FAMTX regimen, and grade 3 or 4 neutropenia was observed in 14 out of the 20 patients (70%). Eleven of these 14 patients required granulocyte colony-stimulating factor support. The overall response rate was 15% (3 PRs in 20 patients). Eighteen resected specimens showed only marginal histological effects (grades 0-Ib). For these reasons, Takahashi and co-workers discontinued the trial.

Because S-1 showed promising effects when used for neoadjuvant chemotherapy against scirrhous gastric cancer in a pilot study [9], we decided to conduct a phase II trial of S-1 to determine its beneficial effects on survival. Because of the difficulty in excluding patients with peritoneal dissemination by conventional diagnostic imaging procedures such as CT scan and the use of barium enema, we performed laparoscopic examination to identify and exclude patients with peritoneal dissemination.

At the time of starting the phase II trial, laparoscopic examination for cancer staging was still not a common procedure. Thus, we need to standardize this technique using a video for the quality control of the procedure. Regarding the historical controls, it was not possible to submit patients without peritoneal dissemination to laparoscopic examination, for the same reason. Data for previous patients with the same eligibility criteria and without peritoneal dissemination, confirmed by laparotomy, were collected from the participating institutions. Thus, in the present study, the control group was not identical to the study group.

Neoadjuvant chemotherapy using S-1 was safe and feasible when compared with other toxic combination chemotherapies. Only a few grade 3 and no grade 4 adverse reactions resulting from cytotoxicity were observed, and no specific morbidity and no increases in morbidity and mortality rates were seen when compared with the data in the historical controls.

Patients with positive cytological examination results were included in this phase II trial. This is the reason why we expected the S-1 neoadjuvant chemotherapy to produce negative cytological examination results. However, the results of the trial, in terms of cytological findings, were not very promising. Without considering the cytological examination results, it can be observed that although there was no significant difference in the curative resection rate between the study group and the historical control group, the curative resection rate in the study group was lower than the expected rate.

From the viewpoint of the pathological therapeutic effects of chemotherapy, S-1 neoadjuvant chemotherapy showed a much better therapeutic effect than FAMTX.

The survival rate of our study group showed a better curve than that of the historical controls; however, it did not reach the expected rate ($P = 0.245$). On the other hand, combination chemotherapy using S-1 and cisplatin (CDDP) showed a markedly high response rate (76%) in a phase II trial. Therefore, this combination can be considered more promising than S-1 monotherapy for neoadjuvant chemotherapy against scirrhous gastric cancer. The JCOG has also completed the accrual of patients evaluated in the phase II trial of neoadjuvant chemotherapy using the above S-1 and CDDP regimen for resectable scirrhous and more-than-8-cm giant type 3 gastric cancer. Because of the superiority of this regimen over S-1 monotherapy in terms of the response rate and pathological therapeutic effects, the JCOG group has already started a phase III trial to confirm the effectiveness of neoadjuvant chemotherapy using S-1 + CDDP as against extended surgery in patients with scirrhous or large type 3 gastric cancer.

In summary, neoadjuvant chemotherapy using S-1 against potentially resectable scirrhous gastric cancer appears feasible and effective; however, in the present phase II trial, the survival rate of the patients did not reach the expected rate. On the other hand, an S-1 + CDDP regimen is now being tested in a phase III trial by the JCOG group as a more promising neoadjuvant regimen.

Acknowledgments This study was supported by a Grant-in-Aid for Cancer Research and the Second Term Comprehensive Strategy for Cancer, both by the Ministry of Health, Labour and Welfare, Japan.

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Quantitative Metabolome Profiling of Colon and Stomach Cancer Microenvironment by Capillary Electrophoresis Time-of-Flight Mass Spectrometry

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Abstract

Most cancer cells predominantly produce energy by glycolysis rather than oxidative phosphorylation via the tricarboxylic acid (TCA) cycle, even in the presence of an adequate oxygen supply (Warburg effect). However, little has been reported regarding the direct measurements of global metabolites in clinical tumor tissues. Here, we applied capillary electrophoresis time-of-flight mass spectrometry, which enables comprehensive and quantitative analysis of charged metabolites, to simultaneously measure their levels in tumor and grossly normal tissues obtained from 16 colon and 12 stomach cancer patients. Quantification of 94 metabolites in colon and 95 metabolites in stomach involved in glycolysis, the pentose phosphate pathway, the TCA and urea cycles, and amino acid and nucleotide metabolisms resulted in the identification of several cancer-specific metabolic traits. Extremely low glucose and high lactate and glycolytic intermediate concentrations were found in both colon and stomach tumor tissues, which indicated enhanced glycolysis and thus confirmed the Warburg effect. Significant accumulation of all amino acids except glutamine in the tumors implied autophagic degradation of proteins and active glutamine breakdown for energy production, i.e., glutaminolysis. In addition, significant organ-specific differences were found in the levels of TCA cycle intermediates, which reflected the dependency of each tissue on aerobic respiration according to oxygen availability. The results uncovered unexpectedly poor nutritional conditions in the actual tumor microenvironment and showed that capillary electrophoresis coupled to mass spectrometry–based metabolomics, which is capable of quantifying the levels of energy metabolites in tissues, could be a powerful tool for the development of novel anticancer agents that target cancer-specific metabolism. [Cancer Res 2009;69(11):4918–25]

Introduction

Most cancer cells are exposed to chronic hypoxia from the early stage of carcinogenesis. Indeed, the measurement of oxygen tension in tumors confirms severe hypoxia in many types of cancer (1). However, cancer cells' predominant use of glycolysis rather than oxidative phosphorylation for energy production, irrespective of oxygen availability (Warburg effect; ref. 2), is widely acknowledged. This indicates that tumor hypoxia is caused not by the excessive oxygen consumption of cancer cells, but rather the inadequate blood supply that results from structurally and functionally defective angiogenesis. In addition, intrinsic characteristics of cancer cells and their constitutive expression of hypoxia-inducible transcription factors activate the genes that encode glycolytic enzymes and glucose transporters (3, 4) and, therefore, jointly hyperactivate glycolysis, to replenish ATP for their continuous growth and proliferation. Nevertheless, the cancer cells' intense use of energy-inefficient glycolysis in the hypovascular microenvironment may deplete glucose from the surrounding tissues. In this manner, the nutritional conditions of the tumor microenvironment may be extremely unfavorable from the perspective of energy metabolism, and significantly different from those that we generally expect from the observation of overgrowing cancer cells.

Although little is known concerning the actual concentrations of glucose and resultant metabolic intermediates in human cancer tissues, the recent development of metabolomics technologies, which are typically based on gas chromatography mass spectrometry (GC-MS; ref. 5), liquid chromatography mass spectrometry (LC-MS; ref. 6), and nuclear magnetic resonance (NMR; ref. 7) is suitable for the large-scale measurement of metabolite levels in tumor and normal tissues. This provides not only direct information on energy metabolism but also the potential reciprocal relationship between metabolic networks and the underlying mechanisms of carcinogenesis.

Recently, metabolome analysis has been applied to the characterization of cancer-cell–specific metabolism. Yang and colleagues (8) applied a computational flux analysis to compare breast cancer and normal human mammary epithelial cell lines by using two-dimensional NMR and GC-MS. Their finding of significant increases in the glycine and proline biosynthesis in cancer cells is interesting, yet may be limited for *in vitro* environment due to its high dependency on culture conditions. Chan and colleagues (9) compared the metabolic profile of biopsied colorectal tumors and their matched normal mucosae obtained from 31 colorectal cancer patients using high-resolution magic angle spinning–NMR and GC-MS and obtained 31 marker metabolites that distinguish normal from malignant samples and further colon from rectal cancers. Moreover, applying GC-MS–based metabolomics, Denkert and colleagues (10) compared the metabolic profiles between invasive ovarian carcinomas and the borderline tumors and between colorectal tumor and pairwise normal tissues (11) and showed that differentially expressed metabolic phenotypes could be exploited

Note: Supplementary data for this article are available at Cancer Research Online (http://cancerres.aacrjournals.org/).

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doi:10.1158/0008-5472.CAN-08-4806

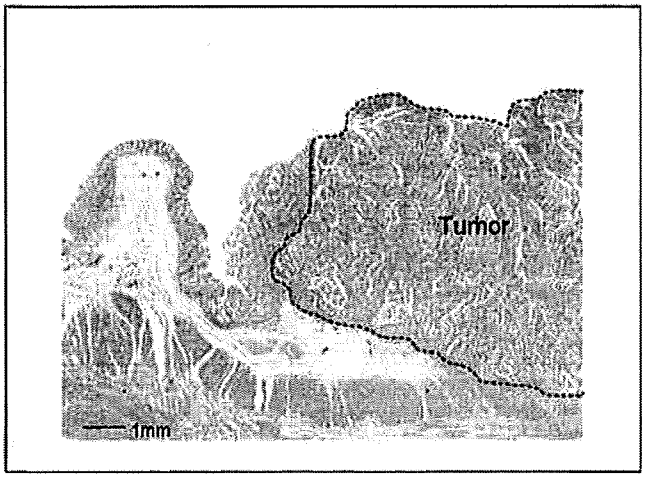

Figure 1. Representative microscopic image of an organ excised from a patient with well-differentiated colorectal adenocarcinoma. Samples were collected from the tumor region (*surrounded by a dotted line*) and nontumor region (considered normal).

to distinguish tumors from the others with high accuracies. However, little has been reported on the quantitation of metabolic intermediates involved in global-scale energy metabolism, including glycolysis, pentose phosphate pathway, and tricarboxylic acid (TCA) cycle, in human cancer and normal tissues. This is mainly due to the lack of effective methodology that allows comprehensive analysis of these metabolites. Most compounds involved in energy metabolism display common properties characterized by high polarity, nonvolatility, and poor detectability, which thus complicates the analysis. We recently developed a state-of-the-art metabolome analysis tool based on capillary electrophoresis coupled to mass spectrometry (CE-MS; refs. 12, 13). The major advantages of CE-MS analysis include its extremely high resolution, versatility to analyze metabolic profiles of various organisms, and ability to simultaneously quantify virtually all the charged low–molecular weight compounds in a sample (12, 14), which makes CE-MS best suited for the comprehensive analysis of energy metabolism in cells, tissues and biological fluids.

In the present study, we applied capillary electrophoresis time-of-flight mass spectrometry (CE-TOFMS; ref. 15) to the metabolome profiling of human colon and stomach cancers, and compared the metabolite levels in tumor and normal tissues obtained by surgery. The results clearly showed that the tumor microenvironment is far from ideal for cell growth from the viewpoint of energy metabolism, and showed the versatility of CE-MS–based metabolomics for global-scale analysis of energy metabolism in tissues.

Materials and Methods

Sample Collection and Metabolite Extraction

We conducted all the experiments according to the study protocol approved by the Institution Review Board of the National Cancer Center upon obtaining informed consent from all the subjects. Tumor and surrounding grossly normal-appearing tissues (Fig. 1) were obtained from 16 colon and 12 stomach cancer patients after surgical treatment. Patient and tumor stage information are listed in Table 1. The excised tissues were cut into <1-cm^3 pieces, immediately frozen in liquid nitrogen, and stored at −80°C until metabolite extraction.

To extract metabolites, preweighed deep-frozen samples (~50 mg each) were completely homogenized by a cell disrupter (MS-100R; TOMY) at 2°C, after adding 625 μL of methanol that contained internal standards [20 μmol/L each of methionine sulfone and 2-(N-morpholino)-ethanesulfonic acid]. The homogenate was then mixed with Milli-Q water and chloroform in a volume ratio of 5:2:5 and centrifuged at 9,000 *g* for 15 min at 4°C. Subsequently, the aqueous solution was centrifugally filtered through a 5-kDa cutoff filter (Millipore) to remove proteins. The filtrate was centrifugally concentrated and dissolved in 50 μL Milli-Q water that contained reference compounds (200 μmol/L each of 3-aminopyrrolidine and trimesate) immediately before CE-TOFMS analysis.

Reagents

Ophthalmate was purchased from BACHEM AG; glycerol-3-phosphate from Nakalai Tesque; sedoheptulose 7-phosphate from Glycoteam; tyramine, CoA, and NADH from MP Biomedicals; and fructose 1,6-bisphosphate, glucose 1-phosphate, ribose 5-phosphate, and ribulose 5-phosphate from Fluka. γ-Glu-Cys and γ-Glu-2-aminobutyrate were synthesized at the Toray Research Center. All other reagents were obtained from either Wako or Sigma-Aldrich. Stock solutions (1–100 mmol/L) were prepared in either Milli-Q water, 0.1 mol/L HCl, or 0.1 mol/L NaOH. All chemical standards were analytic or reagent grade. A mixed solution of the standards was prepared by diluting stock solutions with Milli-Q water immediately before CE-TOFMS analysis.

Analytic Condition for Metabolome Analysis

Instruments. All CE-TOFMS experiments were performed using an Agilent CE Capillary Electrophoresis System equipped with an Agilent TOFMS, an Agilent 1100 isocratic HPLC pump, an Agilent G1603A CE-MS adapter kit, and

Table 1. Patient information and tumor stages

	Characteristic	Colon		Stomach	
		Number	%	Number	%
Position of colon tumor	Rectum	10	63		
	Ascending colon	3	19		
	Transverse colon	1	6		
	Sigmoid colon	2	13		
Stage	I	5	31	2	17
	II	4	25	3	25
	III	6	38	5	42
	IV	1	6	2	17
Sex	Male	11	69	7	58
	Female	5	31	5	42

an Agilent G1607A CE–electrospray ionization (ESI)–MS sprayer kit (Agilent Technologies). For system control and data acquisition, we used Agilent G2201AA ChemStation software for CE and Analyst QS for TOFMS.

For measuring nucleotide derivatives, we used a CE-ESI-quadrupole MS system composed of an Agilent 1100 series MSD mass spectrometer equipped with the aforementioned other instruments. For the control and data acquisition in this system, we used Agilent 3D CE-MSD ChemStation software.

CE-TOFMS Conditions for Cationic Metabolite Analysis

Cationic metabolites were separated in a fused-silica capillary (50 μm i.d. × 100 cm total length) filled with 1 mol/L formic acid as the reference electrolyte (16). Sample solution was injected at 50 mbar for 3 s (~3 nL), and positive voltage of 30 kV was applied. The capillary and sample trays were maintained at 20°C and below 5°C, respectively. Sheath liquid that comprised methanol/water (50% v/v) that contained 0.5 μmol/L reserpine was delivered at 10 μL/min. ESI-TOFMS was operated in the positive ion mode. The capillary voltage was set at 4 kV and a flow rate of nitrogen gas (heater temperature 300°C) was set at 10 psig. In TOFMS, the fragmenter voltage, skimmer voltage, and octapole radio frequency voltage (Oct RFV) were set at 75, 50, and 125 V, respectively. An automatic recalibration function was performed by using two reference masses of reference standards; protonated methanol dimer ($[2\ \text{methanol}+H]^+$, m/z 65.059706) and protonated reserpine ($[M+H]^+$, m/z 607.280659), which provided the lock mass for exact mass measurements. Exact mass data were acquired at the rate of 1.5 cycles/s over a 50 to 1,000 m/z range.

CE-TOFMS Conditions for Anionic Metabolite Analysis

Anionic metabolites were separated in a cationic-polymer–coated SMILE(+) capillary (Nacalai Tesque) filled with 50 mmol/L ammonium acetate solution (pH 8.5) as the reference electrolyte (13). Sample solution was injected at 50 mbar for 30 s (~30 nL) and a negative voltage of −30 kV was applied. Ammonium acetate (5 mmol/L) in 50% methanol/water (50% v/v) that contained 1 μmol/L reserpine was delivered as sheath liquid at 10 μL/min. ESI-TOFMS was operated in the negative ion mode. The capillary voltage was set at 3.5 kV. In TOFMS, the fragmenter voltage, skimmer voltage, and Oct RFV were set at 100, 50, and 200 V, respectively. An automatic recalibration function was performed by using two reference masses of reference standards: deprotonated acetate dimer ($[2M-H]^-$, m/z 119.034984) and deprotonated reserpine ($[M-H]^-$, m/z 607.266107). Other conditions were identical to those used in cationic metabolome analysis.

CE-MS Conditions for Nucleotide-Related Metabolite Analysis

Separations were carried out in a fused-silica capillary (50 μm i.d. × 100 cm total length) filled with 50 mmol/L ammonium acetate solution (pH 7.5) as electrolyte (17). Before the first use, a new capillary was pretreated with preconditioning buffer, 25 mmol/L ammonium acetate/75 mmol/L sodium phosphate solution (pH 7.5), for 20 min. Before each injection, the capillary was equilibrated by flushing with the preconditioning buffer for 10 min and subsequently with the running buffer for 6 min, which was replenished every run using a buffer replenishment system equipped with the Agilent CE. Sample solution was injected at 50 mbar for 30 s (~30 nL). A voltage of +30 kV was applied and a pressure of 50 mbar was applied to the inlet capillary during the run (17). The capillary temperature was maintained at 20°C, and the sample tray was cooled to below 5°C. Ammonium acetate (5 mmol/L) in 50% methanol/water (v/v) was delivered as the sheath liquid at 10 μL/min. ESI-quadrupole MS was operated in the negative ion mode, and the capillary voltage was set at 3.5 kV. A flow of heated dry nitrogen gas (heater temperature 300°C) was switched off during the preconditioning step, and a pressure of 10 psig was applied 0.1 min after sample injection. Compounds were monitored using selective ion monitoring mode.

Liquid Chromatography Tandem Mass Spectrometry Conditions for Glucose Quantification

Liquid chromatography tandem mass spectrometry experiments were performed using an Agilent 1100 series HPLC system and an API3000 triple-quadrupole tandem mass spectrometer (Applied Biosystems), with the Applied Biosystems Analyst software for data acquisition. The separation was carried out on a TSKgel Amide-80 column (2.1 mm i.d. × 25 cm; Tosoh) and the mobile phase consisted of 75% acetonitrile and 25% Milli-Q water at a flow-rate of 0.2 mL/min. The temperature of the column oven was set at 80°C and 1-μL aliquots of the sample solution were injected into the column. Turbo spray mode was selected in the negative ion mode. Nebulizer gas pressure, air curtain gas pressure, nitrogen turbo gas temperature, and ion spray voltage were set at 12 psig, 6 psig, 500°C, and −4.5 kV, respectively. Multiple reaction monitoring detection was performed in MS/MS analysis to obtain sufficient selectivity and sensitivity.

CE-TOFMS Data Processing

Raw data were processed using in house software for the quantitation of metabolites. The overall data processing flow consists of the following steps; noise-filtering, baseline-correction, migration time alignment, peak detection, and integration of peak area from a 0.02 m/z-wide slice of the electropherograms, which resemble the strategies used in widely used data processing software for LC-MS and GC-MS data analysis such as MassHunter (Agilent Technologies) and XCMS (18). Subsequently, the accurate m/z of each peak was calculated by Gaussian curve fitting in the m/z domain, and migration times were normalized using alignment algorithms based on dynamic programming (15, 19). All target metabolites were identified by matching their m/z values and migration times with those of the standard compounds. Processed peak lists were exported for further statistical analysis.

Statistical Analysis

For each sample, the measured metabolite concentrations were normalized using tissue weight to obtain the amount of metabolite contained per gram of each sample. The Wilcoxon matched pairs test was used to compare metabolite levels in tumor and nontumor groups, to determine statistical significance. Z-score normalization was performed and heat maps of metabolite levels were generated using hierarchical clustering based on Pearson correlation coefficients using the MultiExperiment Viewer (MeV) software (Institute for Genomic Research; ref. 20).

Results and Discussion

Metabolome analyses of colon and stomach cancer tissues. We obtained pairs of surgically resected tumor and surrounding normal tissue samples from 16 colon and 12 stomach cancer patients and extracted metabolites for metabolome analysis. Surgically excised tissue samples were immediately frozen in liquid nitrogen, quickly weighed and immersed in methanol with internal standards, and completely homogenized at 2°C, which thus minimized sample degradation and halted potential enzymatic reactions during metabolite extraction process.

The CE-TOFMS systems in three different modes for cation, anion, and nucleotide analyses detected 738 (normal) and 877 (tumor) peaks in colon and 1007 (normal) and 1142 (tumor) peaks in stomach tissues on average, after eliminating redundant peaks, such as spike noises, fragments, and adduct ions. Among these, 94 peaks in colon and 95 peaks in stomach were identified and quantified with metabolite standards by matching the closest m/z values and normalized migration times for further statistical comparisons and interpretations. The identified metabolites and their quantities are listed in Supplementary Table S1 and graphically represented on a large-scale metabolome map (Supplementary Fig. S1).

The relative levels of metabolites in normal and tumor tissues obtained from colon and stomach cancer patients were visualized by using a hierarchical clustering algorithm (Supplementary Fig. S2). The normalized metabolome data were clustered according to metabolites vertically and samples horizontally. Two distinct metabolite clusters were observed in colon tissues: Most

metabolite levels including glycolytic intermediates, amino acids, some TCA and urea cycle intermediates, and nucleosides were higher in tumor tissues compared with their normal counterparts; however, these clusters were less distinguishable in stomach tissues. This trend was also present in the sample clusters: Colon samples were clearly separated into tumor and normal groups except for one normal sample clustered within the tumor group, whereas stomach samples were not well-separated. This indicates that tumor and normal stomach tissues were less distinguishable compared with colon tissues, according to the metabolome data obtained in this study. However, several key metabolites in energy metabolism, such as glucose and nucleoside triphosphates, were lower in both colon and stomach tumor tissues. No significant correlation was found between metabolite levels and the cancer stages of patients in both tissue types (data not shown).

Glycolysis and TCA cycle. As expected from the notion that cancer cells can deplete glucose in the hypovascular microenvironment caused by the hyperactivity of glycolysis, glucose concentrations were much lower in tumor than normal tissues in both types of cancers (Fig. 2). Mean glucose concentration of normal and tumor tissues was 1,220 ± 150 (mean ± SE) and 123 ± 43 nmol/g, respectively, in colon (P = 0.0005) and 1,290 ± 168 and 424 ± 131 nmol/g, respectively, in stomach (P = 0.0068) tissues. Concentrations of metabolites that are involved in glycolysis, pentose phosphate pathway, and TCA cycle are illustrated on a metabolic pathway map in Fig. 3. In colon and stomach cancer, tumor tissues contained nearly equal or higher amounts of glycolytic intermediates than their corresponding normal counterparts, and this trend was clearer in colon tissues. Scarce glucose and modest glucose 6-phosphate concentrations might result from the overexpression of glucose transporters (21) and particularly type II hexokinase expression (22), which are frequently observed in colon and stomach cancer. The accumulation of glucose 1-phosphate in colon cancer is also intriguing in that glycogen synthase kinase 3β expression is reportedly higher in colon cancer cell lines and colorectal cancer patients compared with their respective normal counterparts (23), which may result in the enhancement of glycogenolysis and a continuous supply of glucose 6-phosphate.

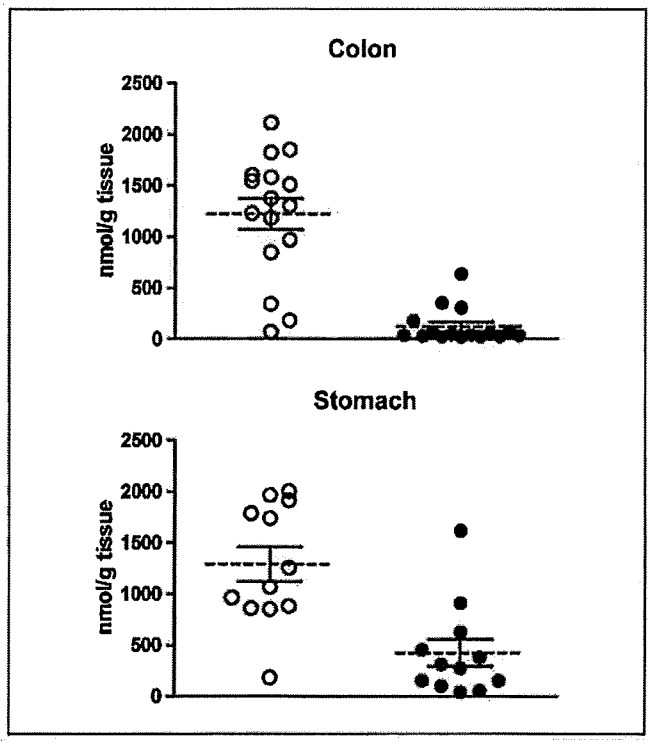

Figure 2. Quantified glucose concentrations of colon and stomach tissue samples. These data are individual glucose concentrations of normal and tumor samples each of colon and stomach subjects, with the mean concentrations (*dotted line*) ± SE.

In addition, pyruvate concentration is significantly lower in colon tumor and slightly lower in stomach tumor tissues, whereas lactate concentration in tumor tissues is higher in both tumor types than in their corresponding normal counterparts. This clearly indicates a high dependence of cancer cells on anaerobic breakdown of pyruvate. In particular, high lactate dehydrogenase 5 activity and resulting effective conversion of pyruvate to lactate have been identified in colon cancer (24, 25). Active glycolysis also increases the cytosolic NADH/NAD^+ ratio and thereby accelerates the activity of lactate dehydrogenase (26). Enhanced pyruvate-to-lactate conversion may also be due to the activation of pyruvate dehydrogenase kinase, isozyme 1 (PDK1) in cancer cells, which inactivates pyruvate dehydrogenase and leads to inactivation of the TCA cycle in cancer cells (27). Moreover, lactate accumulation creates a potentially favorable microenvironment for cancer cells to proliferate, as it causes local acidosis and potentially modulates the activity of proteases that decompose extracellular matrix, thereby liberating peptides and amino acids that are consumable for energy generation (28). Therefore, it is likely that cancer cells preferentially use glucose because of their intrinsic metabolic characteristics and microenvironmental aspects such as hypoxia. Moreover, extremely low glucose content in tumor tissues might result from poor blood supply and high glucose consumption by cancer cells.

If the density of soft tissues is assumed as 1 g/mL, our data indicate that the glucose concentration in tumor tissues is only ~1 of 45 (colon) or 1 of 13 (stomach) of the typical blood glucose concentration (1 mg/mL or 5.6 mmol/L). When cultured cancer cells are deprived of glucose, most conventional cytotoxic anticancer agents significantly lose their effectiveness (29). This is important when the pharmacologic effects of anticancer agents in the actual tumor microenvironment are considered since it was found to be significantly different from the typical glucose-rich medium that is commonly used for *in vitro* experiments. Accordingly, the present data imply that responses of most colon and stomach cancer cells against conventional anticancer drugs under the actual nutritionally poor *in vivo* environment could be considerably different from that which we expect from the data obtained under typical culture conditions.

Unexpectedly, significant organ-specific differences were also observed in the metabolite levels of the initial part of the TCA cycle, including acetyl CoA, citrate, *cis*-aconitate, iso-citrate, and 2-oxoglutarate, which were markedly lower in colon tissues. Interestingly, however, levels of the three TCA metabolites succinate, fumarate, and malate were comparable in colon and stomach tissues, whereas they were significantly higher in tumor samples in both cancers (Fig. 3). Wiesner and colleagues (30) have shown a decrease of citrate and 2-oxoglutarate and an increase of malate and succinate in anoxic rat heart myocytes. The trend of these TCA intermediate levels is consistent with our data obtained from colon tissues, presumably representing a typical metabolic fingerprint of hypoxic cells. In contrast, abundant TCA

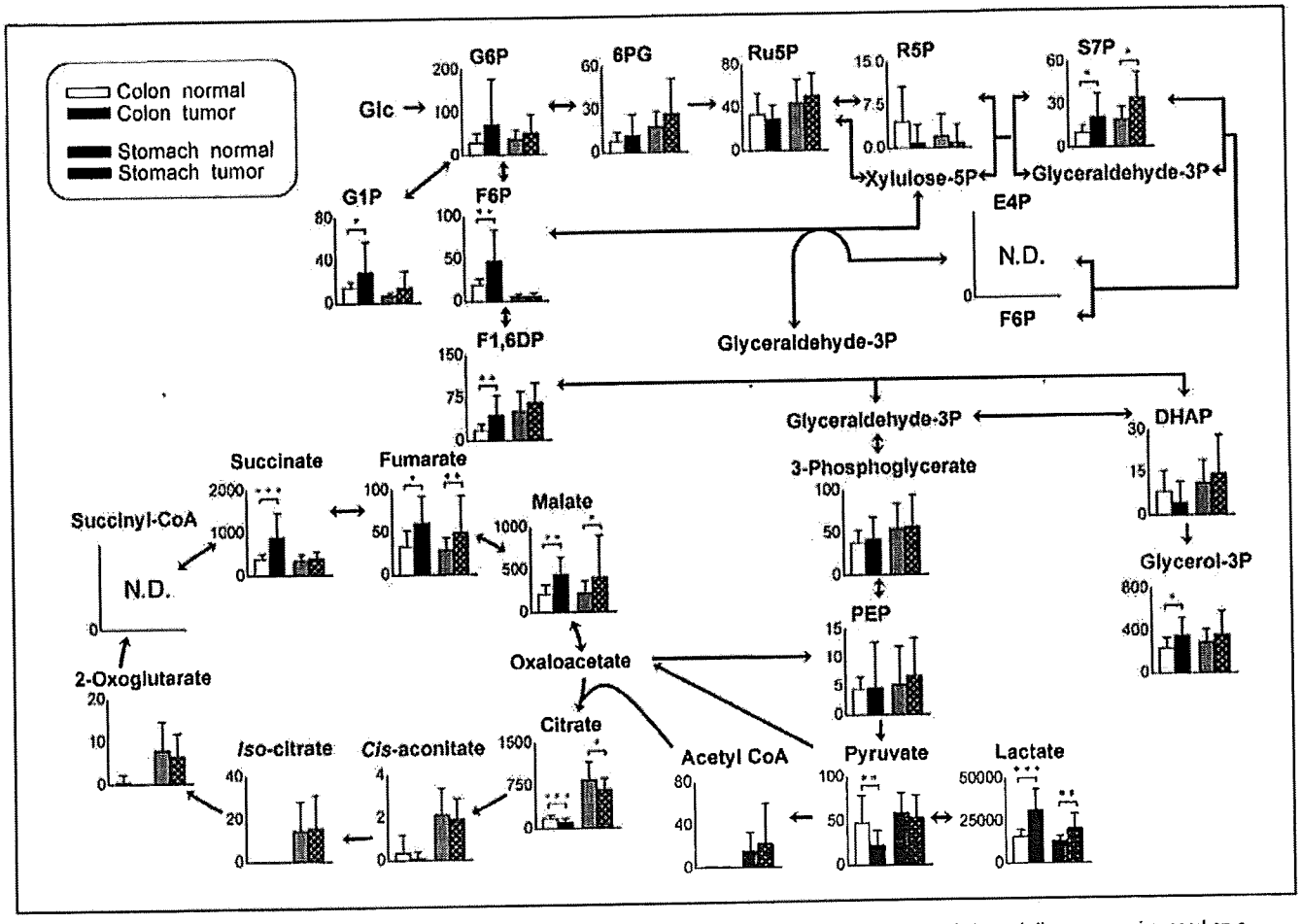

Figure 3. Quantified levels of metabolites involved in central carbon metabolism. Metabolite concentrations of colon and stomach tissues superimposed on a metabolic pathway map that included glycolysis, and the pentose phosphate and TCA pathways. *Columns*, average concentration (nmol/g tissue); *bars*, SD. *N.D.*, metabolic pathway map that included glycolysis, and the pentose phosphate and TCA pathways. *Columns*, average concentration (nmol/g tissue); *bars*, SD. *N.D.*, the metabolite concentration was below the detection limit of the analysis. All the *P* values were evaluated by the Wilcoxon matched pair test. *, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$.

intermediates in stomach tissues, regardless of whether from tumor or normal tissues, imply active aerobic respiration via oxidative phosphorylation. It is uncertain, however, what causes the accumulation of fumarate and succinate in colon cancer tissues, despite extremely low concentrations of other TCA intermediates such as citrate and 2-oxoglutarate. In fact, it is known that some parasites and bacteria synthesize ATP without oxygen by using a reverse reaction of succinate dehydrogenase and produce succinate as a byproduct, which is so-called fumarate respiration, in which fumarate rather than molecular oxygen is used as electron acceptor (31, 32). Although the capability of mammalian cells to use fumarate respiration as an ATP generator has not been confirmed yet, we obtained strong evidence that the energy generation of cancer cells greatly depends on fumarate respiration under conditions of glucose deprivation and severe hypoxia.[3] Our data uncovered the metabolically unfavorable microenvironment of tumor tissues characterized by extremely low glucose availability under relatively hypoxic conditions in which the cells apparently rely on minimal aerobic respiration via the TCA cycle. Hence, the active use of fumarate respiration by cancer cells provides a likely and intriguing explanation for the accumulation of fumarate and succinate observed in colon tumor tissues.

Amino acids and nucleotides. Availability of amino acids is pivotal for cell proliferation because cancer cells are known to use some amino acids as energy sources (26). Free amino acids are mostly supplied to tissues via the bloodstream; thus, if blood supply to cancer tissues is considerably limited, amino acid content in tumor tissues may be lower compared with that in their normal counterparts. However, contrary to our expectations, levels of most amino acids and their primary derivatives were significantly higher in tumors than in normal colon and stomach tissues (Fig. 4). Among all the amino acids, however, an exception was glutamine; the colon and stomach tumor content of which was nearly equal to that in normal tissues. It has been pointed out that glutamine is a preferred amino acid for energy generation by cancer cells (33). High glutaminase activity and low glutamine synthase activity have been observed in several types of cancer cells (34). Because glutamate is the most abundant amino acid in tumor tissues, the conversion of glutamine to glutamate might be enhanced in tumor tissues.

One obvious question raised is the origin of these amino acids. Under limited blood supply, two main sources of amino acids can

[3] K. Kami et al. submitted for publication.

be conceived: one is the degradation of extracellular matrix particularly by matrix metalloproteinases and the other is the autophagic degradation of preexisting intracellular proteins. In this perspective, it is notable that hydroxyproline concentration was significantly higher in tumor tissues than in their normal counterparts (P = 0.0005 in colon and P = 0.0025 in stomach tissues). Hydroxyproline is abundant in collagen and is posttranslationally produced from proline, which suggests that the higher concentration of hydroxyproline in tumor tissues is indicative of excess degradation of collagen (35). Autophagy is another possible source of amino acids, as it is well-documented that autophagy liberates and thereby increases the free amino acid pools (36, 37). We also have found recently that autophagy seems essential for colon cancer cell survival (38) and is highly active in colon and pancreatic cancers (38, 39). Up-regulation of amino acid biosynthesis per se does not explain the accumulation of all the essential amino acids observed in tumor tissues. One might argue that all the amino acid levels seem to be higher in tumors because the number of cells contained in tumor tissues might have been greater than that in normal tissues, as cancer cells may have been highly aggregated. To rule out this possibility, we extracted DNA simultaneously with metabolites from each tissue and normalized our metabolome data with respect to the DNA content of each sample, and confirmed that the trend in amino acid levels did not change (data not shown).

The levels of most nucleotides such as ATP, ADP, GTP, and GDP in tumor and normal colon tissues were significantly lower than those in stomach tissues (Fig. 4). Nevertheless, no significant difference between colon and stomach tissues was observed with regard to the average adenylate energy charge (40), which is evaluated by the equation, [(ATP)+1/2(ADP)]/[(ATP)+(ADP)+(AMP)]. The low levels of most purine and pyrimidine compounds in colon tissues may indicate a relatively slower colon cell growth compared with stomach cells, as a recent study has shown that the nucleotide pools continuously decrease as the growth stage moves from the exponential to stationary phase in *Escherichia coli* (41). A challenging but intriguing alternative is that the levels of nucleotide pools may reflect the oxygen availability and its dependency in each tissue because hypoxic stress has been found to reduce purine and pyrimidine pools (42). The high-energy charge in colon tissues, despite the low total adenylate level, might be maintained by AMP deaminase reaction, which is known to stabilize the energy charge by decomposing adenylate (43). It is, however, remarkable that no significant difference between tumor and normal tissues was found for most nucleotide phosphates, total adenylate, and energy charge in either colon or stomach tissues. This implies that cancer cells have a growth advantage over their normal counterparts, not by securing more ATP and other building blocks for DNA synthesis, but rather by efficiently exploiting some strategic energy

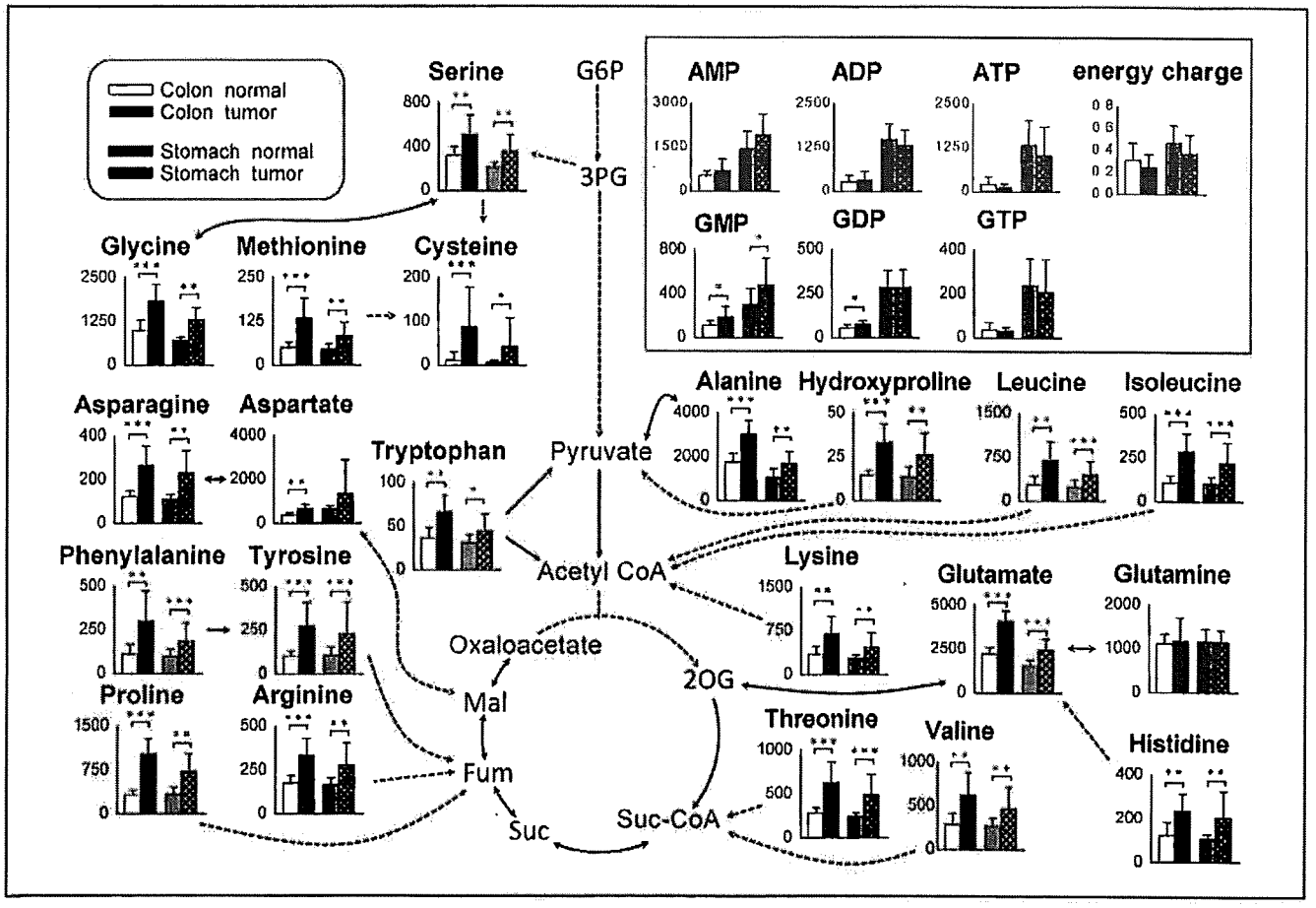

Figure 4. Metabolome data map of metabolites including amino acids, hydroxyproline, and nucleotides (shown in the box) in normal and tumor tissues obtained from colon and stomach cancer patients. *Columns*, average concentration (nmol/g tissue) of normal and tumor tissues; *bars*, SD. *N.D.*, the metabolite concentration was below the detection limit of the analysis. All the P values were evaluated by the Wilcoxon matched pair test. *, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$.

metabolisms such as anaerobic glycolysis, glutaminolysis, autophagic production of amino acids, and possibly fumarate respiration, to maintain comparable levels of principal molecules in spite of limited resources and support continuous proliferation.

Intrasample variability and analytic limitations. Biochemical analysis of tissue samples is relatively difficult due to their high heterogeneity compared with cultured cells or body fluids. To examine the intrasample variability, we extracted metabolites from five different parts of a piece of colon or stomach tumor tissue and measured the metabolite levels by CE-TOFMS (Supplementary Table S2). The relative SDs of most metabolite levels were in the range of 6.7% to 40%. Given that the analytic variability of CE-MS is <5% (16), this relatively high intrasample variability may be attributed to a significantly high intratumor heterogeneity. Therefore, to minimize intrasample variability and thus maximize sensitivity for detecting tumor-specific or even tumor-stage specific metabolic differences, the use of laser capture microdissection for concentrating only the target cells before sample homogenization may be promising.

CE-MS is able to simultaneously quantify charged, low–molecular weight compounds and, thus, is suitable for the analysis of primary energy metabolism; however, it is not very effective for the separation of neutral compounds and macromolecules such as sugars, fats, cholesterols, steroid hormones, and long-chain peptides. Concomitant analysis of the same samples by LC-MS, GC-MS, and NMR approaches has the potential to greatly expand the coverage of target compounds and thereby increase the chance of finding molecular fingerprints of tumors and key markers of the tumorigenic process.

In the present study, we analyzed the metabolic state of tumor tissues in comparison with their normal counterparts and found that the nutritional conditions in the tumor microenvironment were far from ideal from the standpoint of energy metabolism. In particular, tumor glucose concentration was significantly lower than previously indicated (44). The results also indicate that tumors develop tumor-specific metabolism that endows them with more predominant proliferation, independent of tissue types, while retaining some metabolic traits of the tissues from which they originated. In other words, cancer cells are evolved through metabolic adaptation that involves primarily hyperactivation of glucose consumption and accumulation of amino acids, while retaining tissue-specific dependency of aerobic respiration represented by TCA intermediate and nucleotide levels. In conclusion, we analyzed the metabolome-wide tumor microenvironment and revealed cancer- and organ-specific characteristic energy metabolism by CE-TOFMS, which will be a vital technology for the future discovery of tissue-specific cancer biomarkers and for the awaited development of novel cancer therapeutic agents that target cancer-specific metabolic traits.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Acknowledgments

Received 12/17/08; revised 3/9/09; accepted 3/20/09; published OnlineFirst 5/19/09.

Grant support: Third Term Comprehensive 10-year Strategy for Cancer Control from the Ministry of Health, Labour and Welfare and a grant from the Global COE Program entitled, "Human Metabolomic Systems Biology." This work was also supported by KAKENHI (Grant-in-Aid for Scientific Research) on Priority Areas "Systems Genomes" and on "Lifesurveyor" from the Ministry of Education, Culture, Sports, Science and Technology of Japan as well as research funds from the Yamagata prefectural government and the City of Tsuruoka.

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Journal of Surgical Oncology 2009;100:466–471

Clinical and Histopathological Features of Remnant Gastric Cancers, After Gastrectomy for Synchronous Multiple Gastric Cancers

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Background: Remnant gastric cancers have been extensively investigated; however, little has been unveiled the features of remnant gastric cancers with regard to the existence of synchronous multiple lesions. We evaluated the clinicopathological features of remnant gastric cancers, after initial gastrectomy for both single and multiple gastric cancers.

Methods: We retrospectively analyzed 3,042 patients diagnosed with gastric cancers who underwent gastrectomy. Of these, total gastrectomy cases were excluded, and remaining 2,120 cases were investigated.

Results: Among the 2,120 patients, 1,967 patients were histopathologically diagnosed with solitary lesion and 153 patients with multiple lesions. The incidence of remnant gastric cancers was higher in patients with multiple lesions at initial surgery than those with solitary lesion ($P < 0.05$). Moreover, remnant cancers developed within shorter duration of follow-up after treatment of synchronous multiple lesions compared to those that developed after treatment of solitary lesions ($P = 0.05$). Among the patients treated for synchronous multiple lesions, distance from the oral margin was a potential risk factor for the development of secondary cancers in the remnant stomach.

Conclusions: Patients with synchronous multiple gastric cancers are more susceptible to the development of secondary cancers in their remnant stomach. These patients need careful follow-up after initial gastrectomy.

J. Surg. Oncol. 2009;100:466–471. © 2009 Wiley-Liss, Inc.

KEY WORDS: **remnant gastric cancer; multiple gastric cancer; gastrectomy**

INTRODUCTION

In the 1950s, Moertel et al. [1] reported that the incidence of synchronous multiple gastric cancers ranged from 0% to 3.4% in surgically resected specimens, thereafter, due to the advance in diagnostic strategy, series of reports demonstrated that multiple gastric cancers were found in ~4–7% of surgically resected cases [2]. In 1990, Kosaka [3] reported that synchronous multiple gastric cancers were observed in 5.8% of cases, and evaluation using serial sections of the whole stomach revealed that synchronous multiple gastric cancers were noticed in 13.2% of cases, thus, suggesting a higher incidence of latent lesions. Indeed, consistent with this report, Esaki [4] demonstrated the histological evaluation using serial sections of the whole stomach, and found that multiple gastric cancers were present in the resected stomach in 14.6% of cases. These observations suggested that although the incidence of multiple gastric cancers on macroscopic examination of the specimens was <10%, this figure would rise to ~14% if they were also studied using serial sections of the whole stomach.

Remnant gastric cancers are reported to be caused by multiple factors, and their incidence, pathological features, and potential mechanisms have been extensively investigated [5–7]. However, there have been few reports demonstrating the clinical and histopathological features of remnant gastric cancers with regard to the existence of synchronous multiple lesions.

In this study, we examined the clinical and pathological features of remnant gastric cancers after initial gastrectomy for synchronous multiple gastric lesions, and we discussed the potential optimal clinical approaches to the disease.

PATIENTS AND METHODS

Patients

Patients who underwent surgery for gastric cancers were analyzed retrospectively from the database of the Division of the Clinical Pathology in the National Cancer Center Hospital East, from October 1993 to July 2008, after approval from The Investigational Review Board in National Cancer Center. Preoperative diagnosis was based on preoperative imaging studies, including with upper gastrointestinal studies, endoscopy, and conventional cross-sectional imaging studies (computed tomography). Histological evaluation of endoscope-guided biopsy specimens was performed in all cases. Synchronous multiple gastric cancers were defined according to the criteria reported by Moertel et al. [1], which are as follows: (1) each lesion is histologically malignant, (2) each lesion is separated from another by the normal gastric tissue, and (3) each lesion is not the result of a local extension or metastasis of another lesion. If the depth of cancer infiltrations is the same in two or more lesions, the one extending over the greatest area is regarded as the main lesion, and the other lesions are regarded as accessory lesions. In this study, remnant gastric cancers were defined as either of the following two types: (1) cancer in the remnant stomach detected 10 years or more after the initial gastric surgery, and (2) cancer in the remnant stomach that could be identified as a new development not related to the primary lesions [8,9].

Additional Supporting Information may be found in the online version of this article.

There are no financial supports or relationships that may pose a conflict of interest.

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Received 20 January 2009; Accepted 3 June 2009

DOI 10.1002/jso.21352

Published online 3 August 2009 in Wiley InterScience (www.interscience.wiley.com).

The patients' medical records were reviewed for the preclinical stage of the disease, surgical procedures, histopathological findings of the lesions, incidence of remnant gastric cancers, and the outcome.

Histopathological and Immunohistochemical Analysis

The resected stomachs were processed in the usual manner. Briefly, resected stomachs were opened along the greater curvature, placed on a wooden board with the mucosa facing up, and fixed with a 10% formalin solution for at least 24 hr. Several portions, including the distal and proximal stump as well as both main and sub-lesions, were sliced to a thickness of 5 mm and histologically examined. For exploration of multiple lesions, resected specimens were macroscopically evaluated before and after fixation, along with preoperative evaluation, using endoscopy and upper gastrointestinal studies. Furthermore, these examination methods were performed to identify suspected sub-lesions. For the histopathological evaluation, at least two specialized pathologists evaluated all stained slides of the lesions.

The gastric cancers were evaluated according to the General Rules for the Gastric Cancer Study of the Japanese Research Society for Gastric Cancer [10]. A macroscopic pattern of early gastric cancers was classified, according to the Japanese Society for Gastroenterology Endoscopic Criteria, as type I (protruded), type IIa (elevated), type IIb (flat), type IIc (depressed), and type III (excavated). In this study, the histological pattern of gastric cancers were classified into two types; well and moderately differentiated carcinoma were recorded as differentiated type, whereas poorly differentiated or undifferentiated carcinoma were recorded as undifferentiated type [11].

Statistical Analysis

Statistical differences between the two groups were analyzed using the Chi-square test and the Mann–Whitney *U*-test. Univariate and multivariate analyses were performed to evaluate the significance of the clinical and histopathological parameters. A value of $P < 0.05$ was considered statistically significant.

RESULTS

Incidence and Clinicopathological Features of Multifocal Gastric Cancers

From October 1993 to June 2008, 3,042 patients with gastric cancers underwent gastrectomy at the National Cancer Center Hospital East. Of these, 2,776 patients (91.3%) were histologically diagnosed with a solitary lesion, whereas the remaining 266 patients (8.7%) were diagnosed with synchronous multiple gastric cancers in which more than two gastric cancer lesions were found in the resected stomach. Among the 2,776 patients who were histologically diagnosed with a solitary lesion, 809 patients (29.1%) underwent total gastrectomy. On the other hand, among 266 patients who were histologically diagnosed with synchronous multiple cancers, 113 patients (42.4%) underwent total gastrectomy. For the evaluation of the remnant gastric cancers in this study, we excluded the patients who underwent total gastrectomy, and focused on the remaining 1,967 patients with a solitary lesion and 153 patients with multiple lesions. Clinical and histopathological features of the 153 patients with synchronous multiple cancers are shown in Table I. In patients with multiple gastric cancers, the mean age at diagnosis of initial lesions was 63.2 years and significantly older than those with solitary lesion (57.6 years); 109 patients were men and 44 patients were women. The mean number of lesions was 2.23 per patient. The histological types of main lesions were consistent with those of the sub-lesions in 109 patients (71.2%). Of these, the differentiated type was present in 91 patients (59.4%), and the undifferentiated type was present in 18 patients (11.6%), and distribution of the histological types was significantly different compared with the cases with solitary lesion. The average distance between the main lesion and sub-lesions was 28.5 mm. Main lesions were located in the upper third of the stomach in 10 cases (6.5%), in the middle third of the stomach in 78 cases (51.0%), and in the lower third of the stomach in 65 cases (42.5%).

TABLE I. Patients' Characteristics of the Initial Lesions in Patients With Gastric Cancers

	Solitary (n = 1,967)	Multiple (n = 153)	*P*-value
Age (mean, years)	57.6	63.2	<0.05
Gender (M:F)	2.1:1	2.5:1	n.s.
Mean no. of lesions	—	2.23/case	—
Consistency with histological type of the main lesion (total)	—	71.2%	—
Histological type			<0.01
Differentiated-type	43.7%	59.4%	
Undifferentiated-type	51.3%	11.6%	
Average distance between the lesions	—	28.5 mm	—
Location of main lesion			n.s.
The upper third of the stomach	13.5%	6.5%	
The middle third of the stomach	42.5%	51.0%	
The lower third of the stomach	38.6%	42.5%	

Differentiated-type, well- or moderately-differentiated adenocarcinoma; undifferentiated-type, poorly differentiated adenocarcinoma, undifferentiated carcinoma.
Statistical significance between both groups was analyzed by Chi-square test and Mann–Whitney *U*-test.

Supplemental Table I shows the comparison of the histopathological features of the initial lesions (main lesion vs. sub-lesion) among the patients who underwent gastrectomy for multiple lesions. The average tumor size of the main lesion and the sub-lesion was 37.9 and 13.8 mm, respectively ($P < 0.05$). Moreover, 30.7% of the main lesions were histologically diagnosed as undifferentiated carcinoma (poorly differentiated adenocarcinoma or undifferentiated carcinoma), whereas 19.1% of sub-lesions were undifferentiated carcinoma ($P = 0.13$). Furthermore, 73.4% of main lesions were histopathologically found to be mucosal or sub-mucosal lesions, whereas 96.7% of sub-lesions were mucosal or sub-mucosal lesions ($P < 0.05$). Finally, histological examination revealed that 23.7% of main lesions and 4.1% of sub-lesions showed lymph infiltrations ($P < 0.05$), 33.5% of main lesions and 6.9% of sub-lesions showed vascular invasion ($P < 0.05$), and 18.8% of main lesions and 1.3% of sub-lesions showed perineural invasions ($P < 0.05$).

Incidence and Histopathological Features of Remnant Gastric Cancers

Among 153 patients with synchronous multiple gastric cancers, 7 patients (4.5%) developed a secondary lesion in their remnant stomach, whereas 9 out of 1,967 patients (0.45%) developed a secondary lesion in their remnant stomach after initial gastrectomy for a solitary lesion. At initial gastrectomy, the incidence of remnant gastric cancers was significantly higher in patients with multiple cancers compared with those with solitary cancer at initial gastrectomy ($P < 0.05$; Fig. 1A).

As shown in Figure 1B, the average duration of follow-up for the detection of the remnant gastric cancers was 2.12 years in patients with multiple lesions and 3.93 years in patients with a solitary lesion ($P = 0.051$). Clinical and histopathological features of the initial lesions in patients who developed remnant gastric cancers during follow-up are shown in Table II. There were no significant differences between the solitary lesions and multiple lesions in terms of mean age

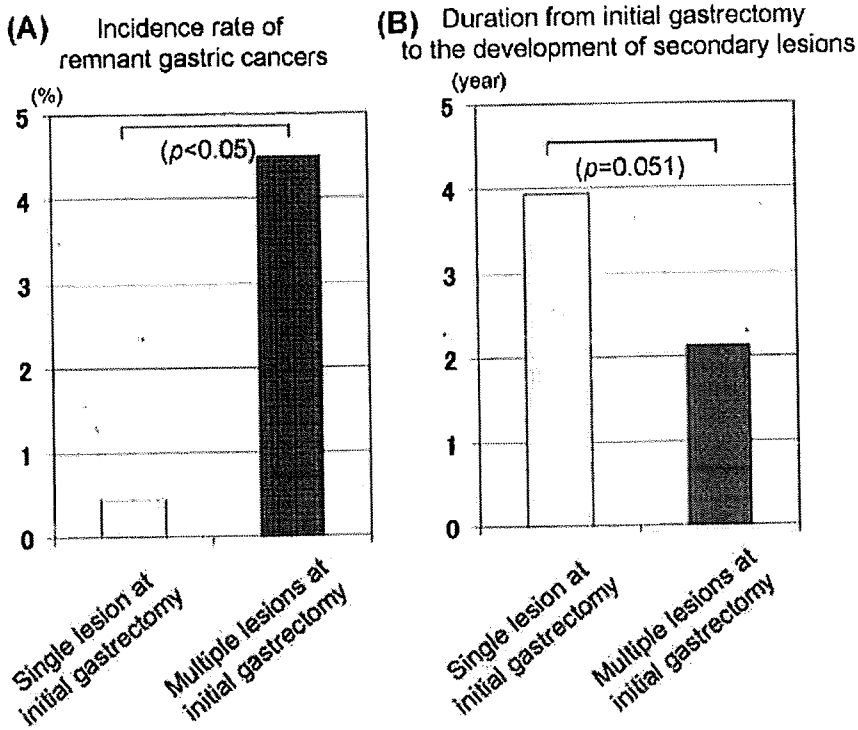


Fig. 1. Comparison of the incidence and interval of remnant gastric cancers after gastrectomy between patients with solitary and patients with synchronous multiple cancers as initial lesions. **A**: The incidence of remnant gastric cancers was significantly higher in patients with synchronous multiple gastric cancers compared to those with solitary lesions (Chi-square test). **B**: The average postoperative interval until detection of secondary cancers in the remnant stomach was shorter in patients with multiple gastric cancers (Chi-square test).

(61.8 years vs. 69.4 years; $P=0.11$), gender (6:3 vs. 6:1; $P=0.77$), population of the undifferentiated lesions (poorly differentiated carcinoma and undifferentiated carcinoma) (44.5% vs. 42.9%; $P=0.78$), histological depth of the invasion (sub-mucosal layer) (55.5% vs. 85.7%; $P=0.14$), mean tumor size (34.8 mm vs. 24.5 mm; $P=0.24$), lymph infiltration (37.5% vs. 15.7%; $P=0.32$), vascular invasion (44.5% vs. 15.3%; $P=0.34$), perineural invasion (22.2% vs. 7.9%; $P=0.53$), percentage of lymph node metastasis (11.1% vs. 0%; $P=0.89$), and location of the main lesions at initial surgery (85.7% vs. 92.3%; $P=0.68$). Table III shows the comparison of the histopathological features of secondary gastric cancer lesions in the remnant stomach. There were no significant differences between remnant gastric cancers that occurred after surgery for a solitary lesion and synchronous multiple lesions in terms of histological differentiation (55.6% vs. 14.3%; $P=0.14$), depth of tumor invasion (sub-mucosal layer) (44.4% vs. 85.7%; $P=0.14$), average size of the tumor (24.4 mm vs. 23.5 mm; $P=0.82$), and percentage of lymph node metastasis (22.2% vs. 0%; $P=0.56$). However, in patients who underwent initial gastrectomy for multiple lesions, a higher percentage of remnant gastric cancers were of the differentiated type and less deeply infiltrated the stomach wall, with no lymph node metastasis.

TABLE II. Comparison of the Clinicopathological Features of the Initial Lesions Which Developed Cancer in the Remnant Stomach During Follow-Up

Variables	Solitary lesion (n=9)	Multiple lesions (n=7)	*P*-value
Age (mean, years)	61.8	69.4	0.11
Gender (M:F)	6:3	6:1	0.77
Differentiation (undifferentiated-type)	44.5%	42.9%	0.78
Depth (m or sm)	55.5%	85.7%	0.14
Tumor size (mean)	34.8 mm	24.5 mm	0.24
Lymph infiltration	37.5%	15.3%	0.32
Vascular invasion	44.5%	15.3%	0.34
Perineural invasion	22.2%	7.69%	0.53
% of pN(+) case	11.1%	0%	0.89
Location (M, ML)	87.5%	92.3%	0.68

Undifferentiated-type, poorly differentiated adenocarcinoma, undifferentiated carcinoma; m or sm, mucosal or sub-mucosal layer of the stomach wall; M, the middle third of the stomach; ML, the lower two-thirds of the stomach.
Statistical significance between both groups was analyzed by Chi-square test and Mann–Whitney *U*-test.

TABLE III. Comparison of the Histopathological Features of the Secondary Cancers on the Remnant Stomach During Follow-Up

Variables	Solitary lesion (n=9)	Multiple lesions (n=7)	*P*-value
Differentiation (differentiated-type)	55.6%	14.3%	0.14
Depth of invasion (m or sm)	44.4%	85.7%	0.14
Tumor size (mean)	24.4 mm	23.5 mm	0.82
% of pN(+) case	22.2%	0%	0.56

Differentiated-type, well- and moderately-differentiated adenocarcinoma; m or sm, mucosa or sub-mucosal layer of the stomach wall.
Statistical significance between both groups was analyzed by Chi-square test and Mann–Whitney *U*-test.

Evaluation of Potential Risk Factors for the Development of Remnant Gastric Cancers After Gastrectomy for Multiple Lesions

Results of our study suggested that patients with multiple gastric cancers are more susceptible to the development of secondary gastric cancers in the remnant stomach (Fig. 1). Thus, to address the potential risk factors for the development of secondary lesions, we examined the differences in the clinical and histopathological features (differentiation of cancer, depth of invasion, size of the lesion, lymph infiltration, vascular invasion, perineural invasion, number of lymph nodes dissected, percentage of the cases with lymph node metastasis, macroscopic type, distance from the margin, location of tumors) of the primary lesions in patients with multiple gastric cancers at initial gastrectomy who developed remnant cancers and those who did not. As shown in Table IV, results of the univariate analysis revealed that there were no statistically significant differences in the percentage of poorly differentiated cancers, histopathological invasion of the lesion, size of the main lesion, percentage of lymph infiltration, percentage of vascular invasion, percentage of perineural invasion, and lymph node metastasis, between patients with and without development of secondary lesions. However, the margin to the oral side of stomach was significantly shorter in patients who developed secondary lesions (40.9 mm vs. 17.9 mm, $P = 0.03$). Furthermore, in patients who developed remnant gastric cancers, a higher percentage of lesions were located in the middle third of the stomach, and the location of the initial lesions (including main and sub-lesions) were significantly different compared to cases with no remnant gastric cancers ($P = 0.048$; Table IV, Fig. 2).

Multivariate analysis revealed that the margin to the oral side of the stomach at initial gastrectomy is a possible indicator for predicting the development of remnant gastric cancers after gastrectomy for synchronous multiple lesions ($P = 0.049$, 95% confidence interval (CI); 0.26–0.97).

DISCUSSION

The incidence of synchronous multiple gastric cancers is reported to be about 4–8%, using standard histopathological analysis of surgically resected specimens [3,12,13]. Several reports have indicated that the incidence of multiple gastric cancers has been increasing in recent years. In particular, studies that involved histopathological exploration of serial sections of the whole stomach showed a higher detection rate of multiple gastric cancers [3,4], which suggests a high frequency of coexistent latent lesions in surgically resected specimens. Detection of multiple gastric cancers could be influenced by several factors, including the method of histopathological analysis. Improvement in diagnostic devices is another important factor contributing to the current higher incidence in detection of multiple lesions.

Clinical and histopathological features of synchronous multiple gastric cancers have been reported sporadically [3,13,14], and it has been demonstrated that multiple gastric cancers are more frequently observed in elderly, predominantly male, patients [12,14]. Consistent with these observations, we found that patients with multiple gastric cancers were relatively old men compared to patients with a solitary lesion. Furthermore, in the present study, most of the lesions in patients with multiple gastric cancers were histopathologically confined to the mucosa or sub-mucosa, and did not infiltrate beyond the sub-mucosal layer of the stomach. These clinicopathological characters of multiple gastric cancers can be understood in several ways. Previous studies of histopathological examinations demonstrated possible associations for the initiation of multiple gastric cancers with intestinal metaplasia of the gastric mucosa [15]. Mai and Takagi [16] investigated the patterns of intestinal metaplasia and the histological type of stomach cancers, and demonstrated that synchronous multiple gastric cancers were frequently found as differentiated adenocarcinomas and were associated with the condition of a diffuse extensive type of intestinal metaplasia. Since a high incidence of intestinal metaplasia is usually observed in the stomach of elderly males [17–19], it is reasonable to assume that patients with multiple gastric cancers are most commonly found among this sub-group. The present study revealed that 71.2% of main lesions in synchronous multiple gastric cancers were consistent with the histological type of sub-lesions, which is compatible with previous observations [20]. This result shows that about 30% of sub-lesions have different histological type from that of main lesions, suggesting that several other factors are involved in the formation of sub-lesions although intestinal metaplasia may be important in the initiation of multiple cancers.

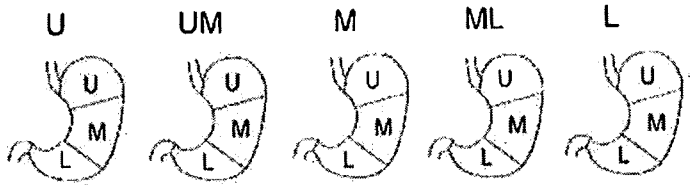
Cancer in the remnant stomach is the focus of much attention not only as a typical model of carcinogenesis, but also from the diagnostic aspect of the lesion. As a result of improvements in outcomes for gastric cancers, more attention to the possibility of formation of remnant gastric cancers is needed during follow-up after initial gastrectomy. Notably, together with advances in diagnostic modalities, the incidence of remnant gastric cancers is reported to be increasing, and the current incidence is ~0.5–1.7% [21–23]. On the other hand, few reports have demonstrated the occurrence rate or clinicopathological characters of remnant gastric cancers that developed after gastrectomy for multiple gastric cancers. Of these, the largest series

TABLE IV. Comparison of the Clinicopathological Features of the Initial Lesions Between the Cases With Or Without Remnant Gastric Cancers Among the Patients With Synchronous Multiple Lesions

Variables	Remnant cancer (−)	Remnant cancer (+)	*P*-value (univariate)	*P*-value (multivariate)
Undifferentiated-type	35.3%	53.8%	n.s.	—
Depth (m or sm)	85.8%	84.6%	n.s.	—
Size of the lesion	24.3 mm	24.6 mm	n.s.	—
Lymph infiltration	12.6%	15.4%	n.s.	—
Vascular invasion	18.8%	23.1%	n.s.	—
Perineural invasion	8.3%	7.7%	n.s.	—
No. dissected LNs	36.7	39.5	n.s.	—
% of pN(+) case	11.1	0.0	n.s.	—
Macroscopic type (type 0-IIc)	68.6%	76.9%	n.s.	—
Distance from margin (mean)	40.4 mm	17.9 mm	0.03	0.049 (0.26–0.97)
Location of the lesion on the middle two-thirds of stomach	37.6%	85.7%	0.048	n.s. (0.38–1.39)

Undifferentiated type, poorly differentiated adenocarcinoma, undifferentiated carcinoma; m or sm, mucosal or sub-mucosal layer of the stomach wall; type 0-IIc, early gastric cancer with depressed type of endoscopic finding.
Statistical significance between both groups was analyzed by Chi-square test and Mann–Whitney *U*-test.

Comparison of location of the initial lesions
between the cases with or without remnant gastric cancers
among the patients that underwent gastrectomy for multiple lesions



Area	U	UM	M	ML	L	p-value*
No remnant Cancer	6(4.3%)	5(3.5%)	42(29.8%)	63(44.7%)	24(17.7%)	0.048
Remnant Cancer	0(0%)	0(0%)	6(85.7%)	1(14.3%)	0(0%)	

Fig. 2. Comparison of the location of initial lesions between patients with and without remnant gastric cancers, among the patients who underwent gastrectomy for multiple lesions. The distribution of initial lesions was significantly different in patients with and without remnant lesions (Chi-square test).

from a Japanese group showed that the incidence of remnant gastric cancers after gastrectomy for solitary gastric cancers was 1.7%, whereas that after surgery for synchronous multiple lesions was 4.7% [20]. Results of our study are consistent with this report; our results add to the previous literature because we demonstrated that the proximal surgical margin is a potential indicator to predict the formation of remnant gastric cancers after gastrectomy for multiple lesions. Furthermore, the present study found that in patients with remnant gastric cancers, the distribution of initial lesions was different from that of the initial lesions in patients without remnant cancers. More than 80% of the lesions in patients with remnant cancers were located in the middle third of the stomach, whereas 60% of lesions in patients without remnant cancers were found in the lower two-thirds of stomach. These results suggest that although no lesions were found in the upper third of the stomach, a higher percentage of multiple cancers tended to be present in the oral side of the stomach in patients with subsequent remnant lesions. This speculation, based on our results which showed a possible association between the oral margin and the potential risk of remnant gastric cancers, seems to be compatible with evidence from previous investigations into the clinical and histopathological aspects of remnant gastric cancers.

We did not examine the area of intestinal metaplasia, nor did we investigate the correlation between the fields of intestinal metaplasia. However, it is reasonable to assume that if the metaplastic area was diffusely extended in the oral direction of the stomach, the mucosa would be more susceptible to the development of a secondary lesion in the proximal area of the stomach. Therefore, there is a high possibility that these lesions would be close to the proximal margin of the stomach. Indeed, to support these speculations, several Japanese investigators have demonstrated that the diffuse type of intestinal metaplasia was found in about 80% of patients with synchronous multiple gastric cancers compared to 40–50% of patients with solitary cancers [15,16,18]. Since the concept of "field cancerization" has been postulated to explain the formation of multifocal gastric cancers [24–26], we should be more cautious in our approach to patients with synchronous multiple gastric cancers, particularly elderly males with diffuse type of intestinal metaplasia. The present study further indicated that although there were no significant differences, a higher percentage of remnant gastric cancers, in patients who underwent gastrectomy for multiple lesions, were of the differentiated type and less deeply infiltrated the stomach wall, with no lymph node metastasis. Thus, postoperative follow-up should be adequately planned to fully examine the remnant stomach, and endoscopic treatment should be considered as a useful option to resect secondary lesions in patients undergoing initial gastrectomy for multiple lesions.

Our study had several limitations. Some patients may have been excluded from analysis because of the lack of complete information about the postoperative findings of endoscopic examination. Endoscopy is the indispensable examination for the follow-up and occasionally the removal of secondary lesions in the remnant stomach; therefore, excluded information could have biased our observations. Moreover, we excluded the cases of total gastrectomy in this study. By excluding all patients that underwent total gastrectomy, the pathological contributions to the development of remnant gastric cancer could have biased. Furthermore, our study covered an almost 15-year period, during which preoperative diagnostic accuracy and postoperative follow-up regimens were different. However, histopathological explorations were consistently performed in the study, which may even be considered a strong point of the study.

In conclusion, the results of our study indicate the following: (1) Patients with synchronous multiple gastric cancers are at potential risk of developing secondary lesions in their remnant stomach after initial surgery. Furthermore, since a series of observations demonstrated that 20–30% of synchronous sub-lesions were detected during histopathological evaluation, we need to be more careful in the preoperative evaluation of these patients. (2) Moreover, in patients with multiple cancers, the supposed risk of secondary lesions is estimated to be around 3–4% in the remnant stomach. Therefore, intense postoperative follow-up is important, and total gastrectomy may be the alternative option in the case with adequate surgical margin cannot be obtained. (3) Since endoscopic exploration is the most reliable examination to detect these remnant lesions [22], patients with synchronous multiple gastric cancers, who are more susceptible to developing secondary gastric lesions in their remnant stomach, should be regularly checked by this technique. In this study, because remnant gastric cancers were detected 2.12 (mean, Fig. 1) years after initial gastrectomy, postoperative follow-up with intense endoscopic examination is required at least first couple of years after initial gastrectomy. Furthermore, given that most remnant gastric cancers after gastrectomy for multiple lesions are differentiated-type and do not infiltrate deep into the sub-mucosal layer of the stomach (Table III), the importance of endoscopic examination is noteworthy not only for detection but also for the subsequent treatment of these lesions on the remnant stomach.

ACKNOWLEDGMENTS

We thank the members of the Division of Digestive Surgery for their critical discussion of this study. We greatly appreciate Dr. Atsushi Ochiai and Dr. Satoshi Fujii for providing us with histopathological suggestions. We also appreciate the members of the Division of Gastrointestinal Medicine for providing us with information about the endoscopic examinations.

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